

Optometry Coding & Billing Alert

Billing Basics: Include These 'Must-Haves' in Third-Party Contracts

Your third-party contracts could be limiting your reimbursement because of their ambiguous or nonexistent coding and billing guidelines.

You can stop payers from denying services not legally covered in your contracts by asking them to explicitly address the following coding and billing scenarios within the contract. This list comes from **Marsha Diamond, CPC**, owner and instructor of Coding Programs, Medical Professional and MD Consultative Services.

1. **E/M services.** Find out in which situations the payer will reimburse them with procedures codes.
2. **Modifier use.** Note modifiers -22 (Unusual procedural services), -52 (Reduced services) and -51 (Multiple procedures), which reduce payment on codes.
3. **Follow-up days.** Ask whether payers follow Medicare guidelines for all follow-up visits, in which case you shouldn't expect payment for follow-up visits not necessary to the condition.
4. **Global period.** Request a list of inclusions and exclusions.
5. **Diagnostic code coverage**, which usually means **medical-necessity guidelines**. Ask whether they follow Medicare's guidelines, which can be very specific.
6. **Down-coding method.** You need to know whether the payer has a method or a computer system that automatically down-codes a level of service based on diagnosis selection, whether your office can be exempt from down-coding if you have less than a certain error rate on services that are typically down-coded on a regular basis, and what the appeals process is for them.
7. **Advance beneficiary notice (ABN).** Find out whether the payer requires this waiver of liability and if you must keep it on file.
8. **Timely filing deadlines and clean-claims definitions.** Some states now require that payers process and adjudicate clean claims by a certain time (note that this adjudication deadline is often not a payment deadline). Medicare will pay interest for a claim it doesn't pay in time, so address interest penalties as well.
9. **Your most-reported codes.** You want explicit payment guidelines for the services that represent 75 percent of your business. If that means simply 10 codes, make sure those 10 codes have specific dollar amounts that you can expect as

reimbursement.

10. **Codes not listed.** Ask your payer to state how it intends to pay for all the other possible codes you could report that don't make it into the contract. At a minimum, your contract should have some language indicating that payments will be based on Medicare rates or a certain percentage until renegotiation.